October 28, 2011

CalPACE Response to Request for Comments on Proposed Frameworks for Dual Eligible Demonstration: Long-Term Care Coordination, Consumer Protections, and Mental Health and Substance Abuse

CalPACE respectfully submits the following responses to the Department of Health Care Services, pursuant to the request of Harbage Consulting for comments on the draft policy frameworks sent out to stakeholders on October 16, in the areas of long-term care coordination, consumer protections, and mental health and substance abuse.

CalPACE represents the five operational PACE programs in California as well as two PACE programs that are expected to become operational in 2012, operated by Los Angeles Jewish Home and CalOptima. In addition, a total of eight organizations have filed letters of intent and several have filed applications to become PACE programs, and several existing PACE programs have filed applications to open new PACE centers, indicating that PACE is a growing and successful model of care for dual eligibles and other persons who meet PACE eligibility requirements.

As you are aware, PACE is a fully integrated, provider-based managed care program for persons over age 55 who meet the Medi-Cal nursing home eligibility criteria, the bulk of whom are dual eligibles. PACE integrates Medicare and Medi-Cal covered benefits including, but not limited to, primary and specialty medical care, adult day care, in-home services, prescription drugs, lab and diagnostic services, physical and occupational therapies, meals, transportation, mental health and behavioral health services, and, when necessary, hospital and nursing home care. Importantly, under the model of care provided by PACE organizations, the organizations are at risk for extended nursing home stays. PACE participants generally stay with their PACE organizations for the last three to four years of their lives. They receive increasingly complex and intensive services and care coordination in their later years of enrollment, all of which PACE organizations remain at full risk for under the capitated payment arrangements they are subject to.

As we have provided to the department in our earlier comments on the Request for Information (RFI), key elements of the PACE model are the use of a comprehensive interdisciplinary team (IDT), personalized care plans, and active care coordination and management, all of which PACE programs provide under capitated payment

agreements. Collectively, PACE programs in California have over 80 years of experience in delivering fully integrated care to frail older adults, all of whom are eligible for placement in a nursing facility from the moment they are admitted to our programs. Numerous studies have found that emergency room, hospital, and nursing home use are lower among PACE participants compared to comparable populations.

While the existing PACE model is a proven model of care for older, dual eligible beneficiaries who meet the nursing home eligibility critera, PACE programs are actively exploring adaptations of the model that have the potential to reach greater numbers of beneficiaries, while utilizing the essential core elements of the PACE model. These include reducing reliance on the PACE Center as the primary location for the delivery of services and expanding the use of contracted community-based providers for delivery of care, and allowing PACE programs to serve populations in addition to those over-55 who are eligible for nursing home placement. Through the National PACE Association, PACE programs are working with CMS to modify regulations and provide flexibilities for programs to pursue these types of adaptations and we look forward to working with DHCS to determine how best to implement these flexibilities in California.

We are pleased that through the expedited enrollment process and assessment tool that have been developed by the DHCS Division of Long-Term Care, effective November 1, PACE programs will have a means of more quickly identifying and enrolling beneficiaries, before their conditions deteriorate. This has been a major impediment to greater expansion of the PACE model. We are grateful to the Department for its development of this expedited enrollment pilot project, and are anxious to test and validate it, so that it can become an ongoing part of the PACE enrollment process. This, coupled with the development of the alternative care approaches mentioned above, will enable PACE programs in California to scale up their operations and to become providers of care to additional dual eligible beneficiaries in California.

We believe it is essential that PACE programs, as well as other providers that currently serve the dual eligible population, have the opportunity to operate side-by-side with contracting plans under the demonstration, and on an equal playing field with respect to enrollment, services, risk, and evaluation of outcomes.

Towards that end, we believe it is essential that all enrollment materials, training, and educational materials include PACE as an option, in areas where it exists, and that all participants have the opportunity to enroll directly into PACE if they so choose. We believe this is consistent with the intent of SB 208 (Steinberg) which states that persons meeting the requirements for PACE may select a PACE plan if one is available in their county.

As we have pointed out in our comments on the RFI, this did not occur in the implementation of the managed care expansion for seniors and persons with disabilities, and the result has been confusion and additional burdens for the department, for PACE programs, and for enrollees, some of whom are required to disenroll from a managed care plan before they can enroll in PACE.

We strongly urge that, for the portion of the dual eligible population that is eligible to enroll in PACE, all plans participating in the demonstration and PACE should be responsible for, and at risk for, providing the same set of services. We believe this should include the full array of services provided under Medicare and Medicaid, including ongoing, extended nursing home stays. We believe that this will ensure that all plans are fully incentivized to provide the preventive, home and community based, and related social services that are needed to prevent unnecessary hospital and nursing home use, and it will ensure a level playing field between the participating plans and other programs that currently serve dual eligibles, such as PACE.

We also believe there should be a mechanism for plans participating in the pilots to be able to refer beneficiaries who meet the nursing home eligibility criteria to PACE programs *before their placement in a nursing home* so that PACE programs, using their expertise, can manage their conditions and continue to keep them in the community.

Finally, we believe that participating plans in the demonstration and other programs serving the dual eligible population must be evaluated using the same outcome measures to enable the department and CMS to determine which models of care provide the best outcomes for beneficiaries.

The remainder of this document outlines the specific comments of CalPACE on the three outlined frameworks for understanding.

Long-Term Care Coordination

We believe the draft framework correctly identifies several critical components to improving and ensuring coordination of long-term care services and supports, including emphasis on care coordination, access to home and community based services, involvement of consumers in the coordinated care team, measurement of quality, and flexible workforce models. PACE programs include all of these elements in the model of care they provide for the frail older adult dual eligible population. As noted in our response to the RFI, these elements are facilitated through the use of a comprehensive Interdisciplinary Team (IDT), which coordinates and manages care across settings. The IDT typically includes the use of a geriatrician/internist, nurse, social worker,

rehabilitation therapist, and behavioral health specialist, but varies depending on the care needs of the individual beneficiary.

From our extensive experience in serving the frailest of the dual eligible population, we believe it is essential that payment and financial incentives be aligned to maximize the use of home and community based medical and social services. This means that all plans serving dual eligibles must be at risk for the full array of services covered by Medicare and Medi-Cal, including primary and specialty care, hospitalizations, and short and long-term nursing home placement. If some plans participating in the pilots are allowed to provide a subset of these services, and are not fully at risk for all services, including extended nursing home stays and hospitalizations, they will have less incentive to invest in preventive and home and community based services.

We strongly concur that the state must aggressively monitor demonstration sites for quality and access. Currently, PACE programs voluntarily undergo annual consumer satisfaction surveys, through an instrument known as I-SAT, as a means of maintaining quality. While participant satisfaction is one measure of quality and should be included in the measurement of success, as noted in our response to the RFI, we believe the demonstration must incorporate a formal evaluation component that stresses both short term and longer term components. For example, outcomes related to reducing inpatient utilization and increasing use of community based services can be evaluated in the short term, while evaluation of nursing home diversion must be evaluated over a longer time frame to capture the full use of these services by participants.

Consumer Protections

The draft framework correctly identifies many key consumer protection measures that are essential to a successful demonstration project, including beneficiary control and choice, beneficiary centered care models, comprehensive benefit design, responsive appeals process, care continuity, enrollment rights and options, oversight and monitoring, appropriate and accessible services, and a phased approach.

In addition to beneficiary control and choice in the provision of care, a fundamental consumer protection is the ability of each consumer to make an informed choice of the type of plan or care arrangement they wish to enroll in, where choices are available. As noted above, it is essential that PACE programs and other providers that serve the dual eligible population have the opportunity to operate side-by-side with contracting plans under the demonstration, that all enrollment materials, training, and educational materials include PACE as an option, in areas where it exists, and that all participants have the opportunity to enroll directly into PACE if they so choose.

We also believe dual eligible consumers will benefit from less fragmentation in the delivery of medical and long-term care services. Currently, a confusing array of Medicare Advantage and Special Needs Plans deliver services to dual eligibles, with little standardization in benefits and services. We believe it is important that all plans and programs participating in the demonstration provide a consistent set of services and benefits, which should be the full array of services and supports available under Medicaid and Medicare. This will facilitate apples-to-apples comparisons for persons enrolling in the pilot, establish clear accountability for care, and enable outcomes to be clearly and consistently measured among participating plans and programs.

With respect to other specific elements of the draft framework, PACE programs are required to honor participants' wishes regarding choice of care provider as well as to provide mechanisms for responding to and resolving complaints. The model of care they provide is 100 percent beneficiary centered. As noted above, PACE programs achieve this through the use of a comprehensive Interdisciplinary Team, which coordinates and manages care across settings. Each PACE participant's needs is assessed regularly. The IDT regularly discusses changes in the participant's health status and makes ongoing revisions to the care plan in response to their changing needs. Consumers and their families or representatives are formally included as part of the care planning process.

As noted above, the benefit design offered by PACE programs is very comprehensive, including many benefits and services that are not recognized as Medicare or Medicaid services, as part of a continuum of medical, behavioral health, and social care designed to keep participants living in the community.

We strongly support the elements of the draft framework that emphasize the need for notice, information, and time for participants to make informed choices of the plan or program they wish to enroll in, including the provision of information in languages besides English.

We also strongly concur with the recommendation that the enrollment process for the dual eligible demonstration can benefit from the lessons learned in the SPD enrollment process. As noted in our response to the RFI, PACE programs were not included in the enrollment documents used in the SPD enrollment process, even though SPDs meeting PACE eligibility criteria are allowed to choose PACE. Given PACEs long history as a pioneer in integrating medical care and long-term care services and supports, we believe PACE must be given equal weight as an option for beneficiaries and they must be able to make an informed decision in a timely way of whether they wish to enroll in PACE.

Mental health and Substance Abuse

As we stressed in our response to the initial RFI, person-centered care requires the full integration of behavioral health services in the pilots. In the case of PACE programs, these services are integrated into a single model of care for duals who are nursing home eligible. The PACE IDT considers behavioral health needs as part of the comprehensive care planning process and proactively implements interventions that prevent unnecessary emergency room and acute inpatient care utilization. As outlined in the draft framework, the fully integrated approach that PACE programs use achieves all of the goals outlined in the framework, including care plans that are tailored to each individual participant; team-based care management; comprehensive screening and referral to services; use of person-centered health homes that utilize communication, coordination, and shared records; use of financial incentives to reduce emergency room and inpatient care utilization; and improved outcomes and lower costs of care.

To provide this model of care it is essential that all necessary behavioral health care services be included among the services plans and programs provide under the pilot and that reimbursement rates reflect the inclusion of these services.

Thank you for the opportunity to provide these comments.